ANNUAL REPORT

FOR THE YEAR ENDED MARCH 31, 1975

MEDICAL SERVICES COMMISSION
OF BRITISH COLUMBIA

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ANNUAL REPORT

FOR THE YEAR ENDED

MARCH 31, 1975

MEDICAL SERVICES COMMISSION

OF BRITISH COLUMBIA

VICTORIA, B.C., January 15, 1976

To His Honour the Lieutenant-Governor of the
Province of British Columbia:

MAY IT PLEASE YOUR HONOUR:

I have the honour, sir, to submit herewith the report of the Medical Services Commission for the fiscal year ended March 31, 1975.

I have the honour to be,

Sir

Your most obedient servant,

R. H. McCLELLAND
Minister of Health

VICTORIA, B.C., January 15, 1976

The Honourable R. H. McClelland,
Minister of Health.

SIR: I have the honour to submit the Annual Report of the Medical Services Commission for the fiscal year ended March 31, 1975.

G. A. STEWART
Chairman

THE BRITISH COLUMBIA MEDICAL SERVICES COMMISSION

Minister

THE HONOURABLE R. H. (BOB) MCCLELLAND, Minister of Health

Chairman

G. A. Stewart

Senior Executive

D. H. Weir, B.A., C.G.A., Assistant to the Chairman
D. M. Bolton, M.D., B.Sc.F., Senior Medical Consultant
A. W. Brown, B. Com., Executive Manager—Plan Administration
W. D. Weston, Assistant Executive Manager—Plan Administration

Annual Report of the Medical Services Commission of British Columbia

I. INTRODUCTION

The Government of the Province established, effective July 1, 1968, an over-all Medical Services Plan which is administered and operated on a nonprofit basis in accordance with the *Medical Services Act* and regulations by and under the supervision of the Medical Services Commission. The Commission is empowered to function as the public authority appointed by the Government of the Province to be responsible to the Minister in respect of the administration and operation of the Plan established under the regulations.

The Medical Services Plan of British Columbia provides a prepaid medical services plan upon uniform terms and conditions for all residents of the Province and their dependants. Insured services under the Plan are paid for insured persons regardless of age, state of health, or financial circumstances, provided the premiums fixed by the Commission are paid. Payment of these services is made, on a fee for services basis according to a tariff of fees approved or prescribed by the Commission, or by salaried, sessional, or contract basis at levels approved by the Commission.

II. BENEFITS UNDER THE PLAN

A. Basic Medical Services

The Medical Services Plan provides insurance coverage for all medically required services rendered by medical practitioners, including osteopathic physicians in British Columbia, and certain surgical procedures of dental surgeons where necessarily performed in a hospital as provided under the *Medical Care Act* of Canada. A contribution from the Federal Government is payable to the Province toward the cost of these insured services on the basis of 50 per cent of the national *per capita* cost of these services multiplied by the average number of insured persons in the Province during the 12-month period ending on the 31st day of March.

B. Additional Benefits

In addition to payment for the above services, additional benefits, when rendered in the Province, are provided without extra premium by the Government of British Columbia. The Federal Government does not share in these costs. All payments are paid only at a tariff of fees approved by the Commission. "Year" means calendar year. A brief description of these additional benefits follows, for exact details *see* the Medical Services Act Regulations.

1. *Chiropractic*—Payment for the services of a registered chiropractor is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over:

No payment for X-rays taken by a chiropractor:

No payment for any chiropractic service performed outside the Province.

2. *Naturopathic*—Payment for services of a naturopathic physician is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over:

No payment for X-rays taken by a naturopathic physician:

No payment for any naturopathic services performed outside the Province.

3. *Orthoptic treatment*—Up to a limit of $50 per patient in any one year and a maximum of $100 per family in any one year, services for orthoptic treatments

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when rendered in the Province of British Columbia to an insured person on the instructions of, or referral by a medical practitioner, shall be paid under the Plan at a tariff of fees approved by the Commission, but there shall be no payment for such services performed outside the Province of British Columbia.

4. *Physiotherapy*—Payment for the services of a registered physiotherapist on the instructions of, or referral by, a medical practitioner where performed other than in general or rehabilitative hospitals, is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over. No payment for any physiotherapy services performed outside the Province.

IMPORTANT—Out-patient physiotherapy services in general hospitals or in rehabilitative hospitals on referral by a medical practitioner are benefits provided by the British Columbia Hospital programs.

5. *Podiatry*—Payment for services of a registered podiatrist is limited to $50 per patient in any one year and a maximum of $100 per family in any one year when rendered other than on the instructions of, or referral by, a medical practitioner within the year.

No payment for X-rays taken by a podiatrist:

No payment for any services performed outside the Province.

6. *Optometry*—Services of registered optometrists are approved for required diagnostic optometric services to determine the presence of any observed abnormality in the visual system. There is no payment for any service performed outside the Province of British Columbia by an optometrist. The Plan does not pay for the fitting or cost of lenses.

7. *Orthodontic*—Service, provided by a dental surgeon for an insured person 20 years of age or younger and which is consequentially necessary in the care of a cleft lip and (or) cleft palate is paid only where that service arises as part of or following plastic surgery repair performed by a medical practitioner. There is no payment for orthodontic services provided outside the Province. There is no payment for dentures, appliances, prostheses, or for general dental services.

8. *Special nursing*—Special nursing services of a registered nurse shall be paid, including the cost of board, to a maximum of $40 per patient in any one year, but only where such services are deemed advisable by a medical practitioner. There shall be no payment for such services performed outside the Province of British Columbia.

9. *Victorian Order of Nursing*—The services of a member of the Victorian Order of Nurses, acting under or with an attending medical practitioner, shall be paid under the Plan at a rate of $2 net per visit to a maximum of $40 per patient per year, but this limit will not apply to the administering of injections on the instructions of a physician. There shall be no payment for any service performed outside the Province of British Columbia by a member of the Victorian Order of Nurses.

III. SERVICES EXCLUDED UNDER THE PLAN

1. Services which are provided under other Federal or Provincial Acts such as the *National Defence Act* of Canada, the *Hospital Insurance Act*, and the *Workers' Compensation Act* of the Province.

2. Pathology, radiology, and (or) electrodiagnostic services performed within the Province at a laboratory that, at the time the service is rendered, is not an approved laboratory for the performance of the service.

3. Services which are not considered to be medically required by the patient, e.g., cosmetic services, examinations at the request of a third party, medico-legal services, advice by telephone, travel charges of a practitioner.

4. While unexpected medical services arising when an insured person is temporarily absent from British Columbia are covered at British Columbia rates, prior authorization in writing from a Medical Director of the Plan is required where the insured person elects to seek medical attention outside the Province, otherwise payment may not be made under the Plan.

IV. PREMIUM RATES AND ASSISTANCE

For those persons having maintained a permanent residence in British Columbia for the 12 consecutive months immediately prior to making application, and who otherwise qualify as eligible under the Medical Grant Act Regulations, premium assistance under the *Medical Grant Act* is available as follows:

(*a*) Applicants who were not liable to pay income tax in the 12 months ending December 31 of the previous year qualify for a subsidy of 90 per cent of the full premium rate:

(*b*) Applicants whose taxable income in the 12 months ending December 31 of the previous year did not exceed $1,000 qualify for a subsidy of 50 per cent of the full premium rates.

Monthly premiums payable by subscribers are as follows:

	Full Premium	If Qualified for— 50 per Cent Subsidy	90 per Cent Subsidy
	$	$	$
One person	5.00	2.50	0.50
Family of two	10.00	5.00	1.00
Family of three or more	12.50	6.25	1.25

(*c*) Temporary Premium Assistance is available for a three-month period under unusual circumstances which by reason of illness, disability, unemployment, or financial hardship render an eligible person unable to pay his currently required premiums for coverage under the Plan. Temporary Premium Assistance is at 90 per cent of the full premium rate.

V. LABORATORY APPROVAL

A six-member Advisory Board on Laboratories, appointed by the Commission, continues to provide advice and recommendations to the Commission pertinent to its determination of approval of laboratories for the performance of insured services under the regulations set down by the Lieutenant-Governor in Council in September 1971. The Commission is responsible for ensuring the reasonable availability of quality laboratory services for insured persons throughout the Province, of controlling the expansion of facilities or provision of new facilities until there is reasonable utilization of existing facilities, and of requiring that, where approved public facilities provide service of equal quality and availability, priority consideration be given to the services provided by such approved public facilities.

VI. PROFESSIONAL REVIEW COMMITTEES

As in the past, the Commission has continued to work closely with the peer review committees of physicians and other practitioners providing services under the Plan.

The Commission provides data to the professional licensing authorities or other relevant practitioner bodies with respect to the volume and type of services rendered under the Plan and various other statistical information on an annual basis, whenever feasible. The Commission also provides various statistical information to them on a request basis.

VII. SALARIED AND SESSIONAL

While most medical services in British Columbia are paid for on a fee-for-services basis, there is, nevertheless, a substantial volume of services paid on a salary or sessional fee basis.

Apart from the Provincial Government, which employs physicians in this way, there are many other organizations within the Province which make arrangements with physicians to provide insured services on this basis and arrange with the Medical Services Commission for reimbursements of their costs.

When the Medical Services Commission reimburses an organization which employs a doctor performing insured services on a salaried basis, a payment is made to the organization for the shareable portion of the doctor's salary, that is the proportion of the salary which represents the time he spent on providing insured services to individuals. An additional amount is paid to cover the relevant overhead costs of the organization employing the doctor. A sessional fee is a payment of a set amount of money for the services of a physician for half a day (three and one-half hours) and the sessional fee includes, where pertinent, a payment for overhead, which goes to the physician because of his continuing overhead costs in his additional private practice.

In the year 1974/75 the total expenditure on medical services by the Medical Services Commission was $211,966,988, which was made up of $201,757,831 in the form of fee-for-service payments and $10,209,157 for salary and sessional payments.

HIGHLIGHTS

The administration of the Medical Services Plan has been through three non-profit societies—the British Columbia Medical Plan, C.U. & C. Health Services Society, and Medical Services Association.

During the year 1973/74 the decision was made to amalgamate administration of the whole Plan to the central offices in Victoria, directly under the Commission. The first step in this change was the dissolution of the British Columbia Medical Plan, effective March 31, 1974. The portion of the Medical Services Plan which had been operated by that society formed the nucleus of the direct administration of the Plan by the Commission. During the year 1974/75 the other two licensed carriers were gradually phased out ahead of the scheduled target date of July 1975 and their administrative responsibilities were assumed by the Commission.

There were two changes in benefits during 1974/75. Effective February 14, 1975, for services of a registered physiotherapist, the limit of $50 per patient and $100 per family per year was increased to $75 per person under age 65 years and $100 per person age 65 years and over per year. Also, effective March 13, 1975, for naturopathic services, the limit of 50 per patient and $100 per family per year was increased to $75 per person under age 65 years and $100 per person age 65 years and over per year.

During the year 1974/75 the Department of Health was restructured in order to provide

(*a*) a greater co-ordination of the activities previously carried out under four separate branches, each reporting directly to the Minister;

(*b*) a more formal and systematic means of assisting the Minister in establishing objectives and policy so essential to delegation;

(*c*) an arrangement which should permit the Minister and senior staff to be able to spend more time on planning and policy analysis.

The resulting reorganization created changes of title and function within the Department. W. J. Lyle, formerly Deputy Minister of Hospital Insurance, was given the responsibility for the Medical Services Commission and for Hospital Insurance with the title of Deputy Minister, Medical and Hospital Programs.

STATISTICAL HIGHLIGHTS

The total expenditure for insured benefits under the Medical Services Plan rose by 20.05 per cent to $211,966,988 in 1974/75 from $176,568,498 in 1973/74. These figures include $8,037,662 in 1973/74 and $10,209,157 in 1974/75 for services rendered by physicians on a salaried, sessional, or contract basis. Total expenditures, including administrative costs, were $224,468,003 in 1974/75, compared to $185,150,292 in 1973/74.

The *per capita* cost of insured medical services (shared by the Federal Government) has risen to $78.56 in 1974/75 from $66.52 in the previous year, based on population statistics provided by the Dominion Bureau of Statistics. The most significant increases were in general practice, laboratory and radiology, and internal medicine.

The *per capita* cost of additional benefits (not shared by the Federal Government) increased to $4.57 from $3.66 the previous year. The most significant increases were in optometric costs and chiropractic costs.

The increase in costs under the Medical Services Plan reflect upward revisions to the agreed schedule of costs for medical practitioners, changes in the additional insured benefits, resulting in increased servicing, increased utilization of insured benefits, changes in the practitioner/population ratio, increased population, and increased administrative costs.

SECTION II

STATISTICAL TABLES

PART I—SUBSCRIBER STATISTICS

Table I—Registration and Persons Covered[1] by Premium Subsidy Level at March 31, 1975

Subsidy (Per Cent)	Subscribers[2]	Persons[2]
90	224,476	367,672
50	28,138	52,768
Nil	793,405	2,022,560
Totals	1,046,019	2,443,000

Table II—Persons Covered[1] by Age-group at March 31, 1975

Age-groups	Persons[2]
Under 1	29,560
1–4	149,267
5–14	440,473
15–24	473,453
25–44	637,623
45–64	468,079
65–69	78,420
70–79	98,209
80–89	44,951
90 and over	7,573
Unknown	15,392
Total	2,443,000

[1] Coverage data do not include members of the Canadian Armed Forces, RCMP, and inmates of Federal penitentiaries.

[2] Subscriber data have been adjusted to agree with the population statistics of the Dominion Bureau of Statistics, and are not comparable to those published in the previous Annual Report.

Figure 1—Coverage by Age-group at March 31, 1975

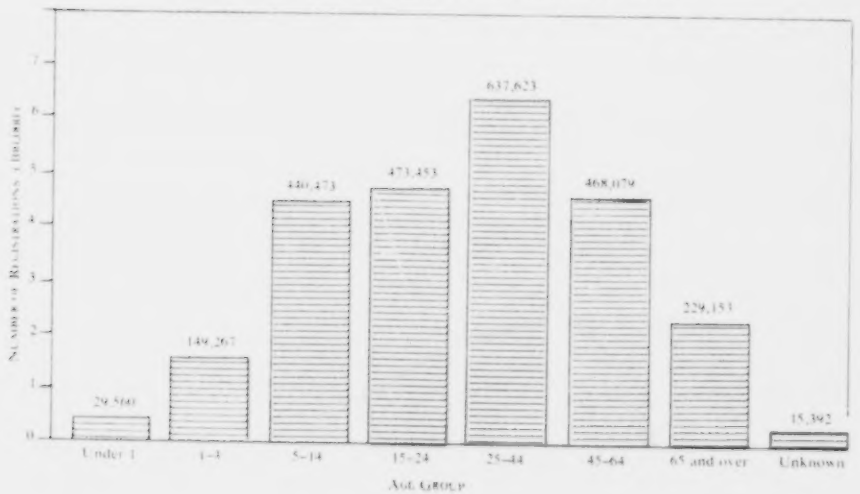
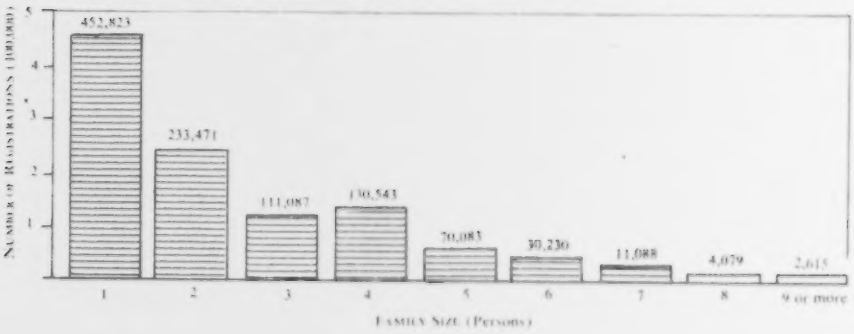


Table III—Coverage by Family Size at March 31, 1975

Family Size (Persons)	Number of Families
1	452,823
2	233,471
3	111,087
4	130,543
5	70,083
6	30,230
7	11,088
8	4,079
9 or more	2,615
Total	1,046,019

Figure 2—Coverage by Family Size at March 31, 1975



PART II—FEE FOR SERVICE PAYMENTS

Medical Practitioners and Dental Surgery in Hospital
(Shareable Under *Medical Care Act*, Canada, and *Hospital Insurance Diagnostic Services Act*)

Table IV—Distribution of Fee-for-service Payments for Medical Services (Shareable)

Specialty	Amount Paid		Percentage of Total		Cost per Person[1]	
	1973/74	1974/75	1973/74	1974/75	1973/74[2]	1974/75
	$	$			$	$
General practice	67,487,760	82,177,788	43.59	43.44	28.9647	34.1270
Dermatology	1,575,525	1,967,399	1.02	1.04	0.6762	0.8170
Neurology	1,202,646	1,330,210	0.78	0.70	0.5162	0.5524
Psychiatry	4,662,309	5,707,746	3.01	3.02	2.0010	2.3703
Neurology and psychiatry	167,264	196,666	0.11	0.10	0.0718	0.0817
Obstetrics and gynæcology	6,052,637	7,040,645	3.91	3.72	2.5977	2.9239
Ophthalmology	6,612,574	7,318,932	3.98	3.87	2.6449	3.0394
Eye, ear, nose, and throat	40,750	79,167	0.03	0.04	0.0173	0.0328
Otolaryngology	2,875,681	3,369,209	1.86	1.78	1.2342	1.3992
General surgery	11,734,262	13,327,682	7.58	7.05	5.0362	5.5348
Neurosurgery	1,046,138	1,113,838	0.68	0.59	0.4490	0.4626
Orthopædic surgery	3,641,230	4,386,095	2.35	2.32	1.5628	1.8215
Plastic surgery	1,130,061	1,329,294	0.73	0.70	0.4850	0.5520
Thoracic surgery	996,843	1,200,697	0.64	0.64	0.4278	0.4986
Urology	2,621,390	3,216,603	1.69	1.70	1.1251	1.3358
Pædiatrics	3,481,484	4,055,096	2.25	2.14	1.4942	1.6840
Internal medicine	9,074,018	11,272,817	5.86	5.96	3.8944	4.6814
Radiology	11,888,791	14,428,831	7.68	7.63	5.1025	5.9920
Pathology	9,229,333	12,957,618	5.96	6.85	3.9611	5.3811
Anæsthesiology	6,412,213	7,371,601	4.14	3.90	2.7520	3.0613
Physical medicine	241,070	308,232	0.16	0.16	0.1035	0.1280
Public health	85,518	72,989	0.06	0.04	0.0367	0.0303
Dental surgery in hospital	455,552	403,906	0.29	0.21	0.1955	0.1677
Osteopathy	174,539	206,284	0.11	0.11	0.0749	0.0857
Unclassified	2,378,209	4,323,452	1.54	2.29	1.0956	1.7955
Totals	154,817,797	189,162,797	100.00	100.00	66.5203	78.5560

[1] Based on population as at October 1, as provided by the Dominion Bureau of Statistics (October 1, 1973=2,330,000; October 1, 1974=2,408,000).

[2] The 1973/74 cost per person data in this Report differ slightly from that given in the 1973/74 Report due to the change in the population base used. The 1973/74 Report used Plan population data; the 1974/75 Report uses Federal population data.

Table V—Distribution of Medical Fee-for-service Payments and Services by Type of Service

	Number of Services		Amount Paid	
	1973/74	1974/75	1973/74	1974/75
			$	$
General Practitioners				
Complete examination	567,390	694,421	7,808,266	10,343,599
Partial examination	3,650,467	4,245,887	25,849,320	32,489,645
Subsequent office visit	1,923,942	2,011,831	8,634,121	9,684,592
Night, Sunday, holiday, or emergency visit	375,470	450,746	6,498,828	8,519,867
First house visit	101,839	117,812	1,317,060	1,704,113
Subsequent house visit	52,213	55,845	535,727	640,000
Hospital visit	1,530,767	1,594,119	5,777,174	6,376,835
Subtotals	8,202,088	9,170,661	56,420,496	69,759,144
Specialist				
Consultation	630,684	693,882	16,264,180	19,715,426
House visit	4,521	5,516	106,323	149,076
Office visit	323,539	357,088	1,869,621	2,224,673
Hospital visit	385,444	425,857	2,458,908	2,962,854
Subtotals	1,344,188	1,482,343	20,699,032	25,052,029
Other Medical				
Anæsthesia	1,630,180	1,741,178	8,352,549	9,601,240
Obstetrics	47,563	47,683	5,585,280	6,109,361
Surgery	404,842	411,828	23,330,098	26,542,660
Special procedures	539,372	600,370	6,238,480	7,721,035
X-ray	964,235	1,072,759	11,949,275	14,333,678
Laboratory	4,062,663	4,961,588	12,456,976	16,966,158
Common office procedures	1,124,610	1,196,042	4,619,943	5,352,581
Psychotherapy	197,098	201,022	3,676,585	4,474,470
Electrodiagnosis	13,918	14,294	303,775	381,530
Miscellaneous	10,987	11,802	1,185,310	2,868,910
Subtotals	8,995,468	10,258,566	77,698,271	94,351,623
Totals	18,541,744	20,911,570	154,817,799	189,162,796

Table VI—Average Fee-for-service Payments by Type of Practice[1]

Type of Practice	Number of Active Practitioners[2]		Average Payment[2]		Median Payment[2]	
	1973/74	1974/75	1973/74	1974/75	1973/74	1974/75
			$	$	$	$
General practice	1,304	1,395	46,396	53,620	46,365	52,872
Dermatology	26	30	57,949	59,920	53,496	57,808
Neurology	18	21	58,352	64,124	64,731	63,689
Psychiatry	94	94	42,026	51,293	43,447	50,989
Neuropsychiatry	2	2	77,421	93,901	77,421	93,901
Obstetrics and gynæcology	98	100	58,911	67,420	57,903	67,167
Ophthalmology	103	107	58,843	67,476	56,075	65,310
Otolaryngology	44	48	65,586	72,319	63,645	69,659
General surgery	143	144	57,944	66,650	55,058	65,321
Neurosurgery	19	18	54,447	60,773	55,916	57,404
Orthopædic surgery	65	70	54,159	61,700	52,676	58,712
Plastic surgery	20	21	56,300	60,954	56,657	60,991
Thoracic and cardiovascular surgery	12	13	92,041	103,025	80,431	112,629
Urology	47	47	55,065	67,036	53,988	64,896
Pædiatrics	41	48	50,375	55,210	48,221	54,001
Internal medicine	123	128	53,784	66,357	51,683	60,483
Anæsthesia	149	157	42,191	46,826	42,704	46,986
Eye, ear, nose, throat	1		23,795		23,795	
Physical medicine	5	4	42,855	52,417	42,112	49,283
Osteopathy	3	3	47,426	58,759	40,407	46,126
Surgery, general practice[3]	18	18	39,951	48,507	37,338	49,848
Pædiatrics, general practice[3]	20	20	55,115	54,483	46,731	46,815
Internal medicine, general practice[3]	22	18	37,611	41,060	35,490	36,718

[1] Type of practice is based on practice being carried out rather than on certification.
[2] Includes only those physicians whose services on a fee-for-service basis grossed $20,000 or more.
[3] These are special classifications created for statistical purposes. Physicians in these categories are certified specialists, but derive 50 per cent or more of their income from general practice services.

PART III—ADDITIONAL BENEFITS

Fee-for-service Payments, Nonshareable by Federal Government

Table VII—Distribution of Fee-for-service Payments for Insured Services, Nonshareable Additional Benefits

Type of Service	Amount Paid[1]		Percentage of Total		Cost per Person[2]	
	1973/74	1974/75	1973/74	1974/75	1973/74[3]	1974/75
	$	$			$	$
Special nursing	5,553	4,721	0.07	0.04	0.0024	0.0020
Victorian Order of Nursing	160,451	75,565	1.88	0.69	0.0689	0.0314
Red Cross	14,474	12,798	0.17	0.12	0.0062	0.0053
Chiropractic	3,786,597	5,747,051	44.45	52.17	1.6251	2.3866
Naturopathic	203,400	191,174	2.39	1.74	0.0873	0.0794
Physiotherapy (office)	1,162,967	1,290,244	13.65	11.71	0.4991	0.5358
Physiotherapy (hospital)	157,703	829	1.85	0.01	0.0677	0.0004
Orthoptic	2,720	3,928	0.03	0.04	0.0012	0.0016
Podiatry	899,311	1,014,628	10.56	9.21	0.3860	0.4214
Optometric	2,125,743	2,671,380	24.95	24.25	0.9123	1.1094
Unclassified	107	2,512	0.00	0.02	0.0000	0.0010
Totals	8,519,026	11,014,830	100.00	100.00	3.6562	4.5743

[1] These amounts are fee-for-service payments paid under the Plan only, and in no way reflect the total for the services of these practitioners.

[2] Based on population as at October 1, as provided by the Dominion Bureau of Statistics (October 1, 1973=2,330,000; October 1, 1974=2,408,000).

[3] The 1973/74 cost per person data in this Report differ slightly from that given in the 1973/74 Report due to the change in the population base used. The 1973/74 Report used Plan population data; the 1974/75 Report uses Federal population data.

Table VIII—Average Fee-for-service Payments by Type of Practice, Nonshareable Additional Benefits

Type of Practice	Number of Active Practitioners[1]		Average Payment[1]		Median Payment[1]	
	1973/74	1974/75	1973/74	1974/75	1973/74	1974/75
			$	$	$	$
Chiropractic	145	158	25,106	34,702	23,026	33,158
Naturopathic	7	7	25,332	23,989	23,209	23,216
Physiotherapy	38	38	24,425	27,626	22,648	27,127
Podiatry	22	24	37,859	38,543	36,483	40,064
Optometry	108	122	17,533	20,691	16,370	18,658

[1] Includes only those practitioners whose payments from the British Columbia Medical Services Commission grossed $10,000 or more. It must be emphasized that these payments in no way represent the practitioners' total income or net income.

SECTION III

FINANCIAL STATEMENTS

Exhibit A

THE OVERALL MEDICAL SERVICES PLAN OF BRITISH COLUMBIA OPERATED BY AND UNDER THE MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF FINANCIAL POSITION
as at March 31, 1975

	$
ASSETS	
Cash	4,787,904
Investments	41,000,000
Due from Consolidated Revenue Fund pursuant to section 11, *Medical Services Act*—Exhibit B	1,544,256
	47,332,160
LIABILITIES	
Estimated liability for unpresented and unprocessed benefit costs	
Medical care	36,263,808
Additional benefits	2,020,048
	38,283,856
Premiums paid in advance	9,048,304
	47,332,160

The accompanying notes are an integral part of these financial statements.

Approved on behalf of the Commission

G. A. STEWART
Chairman, Medical Services Commission of British Columbia

AUDITOR'S REPORT

I have examined the statement of financial position of The Overall Medical Services Plan of British Columbia and its licensed carriers operating under the direction and control of the Medical Services Commission of British Columbia as at March 31, 1975, and the related statement of operations and contingency reserve for the year then ended. My examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as I considered necessary in the circumstances.

In my opinion these financial statements present fairly the financial position of The Overall Medical Services Plan as at March 31, 1975, and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

August 1, 1975,
Victoria, B.C.

J. W. MINTY, C.A.
Comptroller-General

Exhibit B

THE OVERALL MEDICAL SERVICES PLAN OF BRITISH COLUMBIA
OPERATED BY AND UNDER THE
MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF OPERATIONS AND CONTINGENCY RESERVE
for the year ended March 31, 1975

	$	$
INCOME		
Subscribers' premiums	88,930,257	
Adjustment of provision for prepaid premiums	279,738	
	89,209,995	
Government of British Columbia	19,175,882	
Investment income	5,323,636	
		113,709,513
Government of Canada *re Medical Care Act*		81,541,066
Government of Canada *re Hospital Insurance and Diagnostic Services Act*		9,864,031
		205,114,610
EXPENDITURE		
Benefits		
Medical care	199,371,953	
Additional benefits	11,014,830	
	210,386,783	
Adjustment of provision for unpresented and unprocessed benefit costs	1,580,205	
		211,966,988
Administration *re* licensed carriers (M.S.A. and C.U. & C.)		
Salaries and employee benefits	2,768,825	
General office expenses	1,486,414	
		4,255,239
Commission General Administration *re* Medical Services Plan		
Salaries and employee benefits	4,099,185	
General office expenses	2,038,120	
		6,137,305
Amalgamation administration expenses		
Salaries and employee benefits	1,409,346	
General office expenses	699,125	
		2,108,471
		224,468,003
Excess of expenditure over revenue		19,353,393
Contingency reserve at beginning of year		17,809,137
Due from Consolidated Revenue Fund—Exhibit A		1,544,256

The accompanying notes are an integral part of these financial statements.

THE OVERALL MEDICAL SERVICES PLAN OF BRITISH COLUMBIA
OPERATED BY AND UNDER THE
MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

NOTES TO THE FINANCIAL STATEMENTS
for the year ended March 31, 1975

1. Accounting Policies

Income determination—The Commission recognizes premium income as it is received from its licensed carriers. Premiums paid in advance are shown as a liability until the month in which they are earned. Interest and Government grants are recognized as income when received.

Benefit costs—The Commission provides for unpresented and unprocessed benefit costs. These costs are charged to income for the year on the basis of historical claims experience relating to operations conducted to March 31, 1975.

Administration expenses—The public sector activities of the licensed carriers, Medical Services Association and C.U. & C. Health Services Society, are in process of amalgamation with the operations of the Medical Services Plan of British Columbia. This has resulted in certain nonrecurring expenses which have been shown separately in the Statement of Operations.

2. Investments

Investments consist of short-term deposits with commercial banks and are recorded at cost.

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in right of the Province of British Columbia.
1975

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